

A tool for health system description. Diagnosing the Polish system¹

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■ Abstract

The article presents the thesis that there is information available in the public sphere on the basis of which the situation in the Polish health system can be diagnosed. Such a diagnosis would make it possible to identify the problems experienced by patients as ailments and other problems which may lead to missing the chance of positive impact on the health condition. Since the study is focused on and confined to the diagnosis of problems, especially those perceived by patients as limiting, and leaves their explanation to be considered further, the range of sources is necessarily restricted. The following sources are indicated: WHO reports, European Health Consumer Index reports, Centre for Public Opinion Research (Pol. CBOS) reports, National Health Fund (Pol. NFZ) annual reports, WHC BAROMETER results and OECD documents. On this basis, it can be argued that a serious problem for the system is the multi-cause perception of the patients' failure to meet their health needs, long waiting times for specialist consultation, diagnostic tests and hospitalisations, shortage of time and attention devoted to patients, issues of equal treatment of patients and – oftentimes – dissatisfaction with the functioning of the system. After formulating the outline of the diagnosis presented in this text, considerations were made aimed at explaining the revealed problems.

Key words: health system, Polish health system, diagnosis of the system

Słowa kluczowe: diagnoza systemu zdrowotnego, Polska, system zdrowotny



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Przygotowanie do wydania elektronicznego finansowane w ramach umowy 637/P-DUN/2019 ze środków Ministerstwa Nauki i Szkolnictwa Wyższego przeznaczonych na działalność upowszechniającą naukę.

One of the elementary postulates of a rationally conducted health policy is to treat the description of the situation in relation to which the position is to be taken as a starting point for any decision [1]. Formulated differently, it can be said that the condition for a sensible decision is the diagnosis of the problem because without it, finding an effective tool for its solution, or speaking more broadly, inducing a beneficial change, can at most be accidental. At the level of declarations, the vast majority of researchers and political decision-makers agree that it is worth starting with the identification of actual problems, but the practice of many reform activities undertaken over the last decades in many countries indicates that in many situations the content of proposed changes was not the solution to the problem diagnosed, and often it was a transfer of ideas that were

invented elsewhere, often in a completely different institutional and cultural environment. Sometimes it results from the conviction that different solutions applied in the health sector have universal effectiveness, and that local particularisms, such as their own history and tradition do not impact the effects of their application, leading to the conclusion that a detailed diagnosis of the situation is not necessary [2]. In the practice of reforming, however, the source of inspiration would sometimes be the fashionable belief in the usefulness of the mechanism at a given time, as it was – and sometimes still is – the case with the market mechanism [3]. Nevertheless, on many occasions, the justification for undertaking reform measures without first diagnosing the situation was that the decision-makers did not have sufficient information that would enable them to describe the starting point

in more detail [4]. This could often be due to the malfunctioning of the reporting systems, in which the abundance of many retail data would lack what was crucial for the diagnosis [5]. At the same time, the pressure of expectations exerted by dissatisfied patients or impatient voters, i.e. the need for urgent interventions, made it impossible to patiently collect the necessary information.

Haste in making decisions may be associated with a low interest of decision-makers in taking action to effectively solve problems, while making 'some' decisions may be a good manifestation of political activity – the opposite of 'impossibilism'. Political activity manifesting itself as a readiness to make decisions, without worrying about the quality of the implemented solution, is often a convincing argument in the battle for votes. Nevertheless, it is a fact that in many countries health statistics are conducted vaguely and non-systematically, especially in less developed countries, which can be used as an excuse for abstaining from the empirical recognition of the problem. Despite all the weaknesses, practically always, in every country and in every situation, some information *is* collected and so *can* be used. Its completeness and quality may often raise concerns, especially in the case of a methodological purist, but in order to ensure rational treatment of decisions in this sphere, it is always better to use incomplete data than none at all. This is important not only because of its effectiveness, but also because it is essential in any attempt to estimate the results. It may happen that despite efforts made in the best faith and the introduction of various financial or institutional changes, the planned or even imagined effect has not taken place. Not knowing what the reality of the health sector or health condition looked like before the reform interventions, the decision-maker is not able to notice the occurrence or non-existence of reactions.

In this article, which focuses on the realities of the Polish health system, I intend to pursue two objectives. First of all, I intend to point out, or at least call attention to the fact that there are many sources from which information on the situation in the Polish health system can be drawn. These are national, but also international studies presenting hard numerical data, as well as interpretations and comments on the resources and functioning of the system. An advantage of both is their availability: it comes when they are in use no additional cost is generated as they already exist. The domestically produced information is usually faster to be available though it is not always the case.² An indisputable advantage of texts prepared by international institutions is the use of mechanisms verifying the reliability of presented data and a coherent methodology, enabling comparisons between countries, as well as impartiality in identifying difficulties in places which could be completely omitted by national observers. Negating the existence of different problems in national studies may be the result of an intentional tendency to hide difficult issues – no authority likes to admit defeat – but it may also be the result of conceptual or methodological shortcomings. Therefore, national researchers

sometimes do not perceive various issues as difficult and solvable, even though the same issues are taken seriously and responsibly in another country. The inspiring role of international comparisons often cannot be overestimated. This may include hard facts and their interpretation, as well as the results of opinion polls of people who are or may be entitled to benefits provided by the system. Information is often available for subsequent years to determine changes in the intensity of the phenomenon. Secondly, within the framework of this study, using the available information, I will try to describe situations that can be treated as difficult and that should be perceived as a set of problems to be solved. I accept the point of view of the beneficiaries, because they are the addressees of the system's operation and the barriers they encounter should be a strong impulse for decision-makers to be active in removing the existing obstacles and improving the effectiveness of the functioning of particular elements of the system. This is a perspective that consciously limits the scope of information taken into account. The point is that many of them can be perceived more as a tool to solve problems than as a problem in itself. This may be the case for different aspects of resources, or rather lack of resources: increasing funding when there is a shortage of money, or increasing the number of staff when there is a shortage of staff, are measures to address the problems faced by users. Therefore, I accept that it is not limited resources that are a problem, although this can be seen and treated as the cause of many problems. This is a distinctly different approach from the many diagnoses that have been made in numerous studies proposing and justifying changes to the health system.

The diagnosis being constructed, or rather reconstructed in this text, does not aspire to be original, because all the constituent elements have already been established and presented somewhere else, and their (relatively) easy availability is one of the initial premises of the analysis. Practically all analyses of the Polish system use information from various sources [7]. The difference between my proposal and other studies or original sources and findings is to be found in the overall nature of the proposed technical tool, which will make it easier to establish a list of important issues from many points of view, including the most important ones, namely setting priorities. In a world of limited resources in which health policy inevitably revolves, the factually rooted determination of what is most important to be resolved should be treated as the basis for rational decisions. The proposed diagnosis should therefore present the circumstances that are – or at least should be – treated as problems to be solved using the tools at the disposal of the decision-makers. According to the available information, the dynamics of the phenomenon will be presented by using the earliest possible source of information and comparing it with the latest possible information. And so, the starting point are the sources of information and they are the basis for my deliberations, but the different practices used

by the authors of the various sources do not allow for the adoption of a uniform timeframe for the presented phenomena. Therefore, the description should not use 'external' theoretical constructions, which would sort the described material. In the presented paper, attention is paid only to the attempt to diagnose the system, leaving other motifs of the analysis – the attempt to provide an explanation – to the considerations presented further.

Source: WHO

A report prepared by the World Health Organisation in 2000 played an important role among the various research projects in which the problem of health systems was addressed. An attempt was made to assess the functioning of health systems in individual countries on the basis of empirical indicators, thus going beyond the previous practice of creating positive patterns, reflecting the reality only to some extent. The Report concludes that "the health system is defined as comprising all activities whose primary purpose is to promote, restore and maintain health" [8], and further that health systems "cover all organisations, institutions and resources devoted to health activities" Health action, on the other hand, is "any effort already made in the fields of individual and public health, including using cross-sectoral initiatives aimed primarily at improving health" [8].³ Therefore, the Report concludes that the *raison d'être* and defining characteristic of this system is to take action to promote health. The health objective was operationalised using the DALY (Disability Adjusted Life Years) indicator. However, this was not the only goal. In addition, the system should pursue the objective called responsiveness, which was to consist in the ability of the system to respond to the expectations and needs of its users. It concerns the way people are treated, namely the elements of behavioural culture, respect, patience and empathy. These are not, of course, objectives exclusively belonging to the health system, but they are certainly important especially for the sick, and so more vulnerable people. The second important objective, apart from health, was fairness, which had a double meaning. According to it, the health system is required to respond equally to the needs of all recipients of services, in a manner that excludes discrimination against anyone, but also to ensure a balanced and non-discriminatory distribution of responsibilities related to financing the system's activities. It is well known that therapeutic activities cost money, and the costs may be incurred by a sick person who, at the time of illness, has limited earning opportunities. Moreover, chronically ill people also have difficulties on the labour market, so they should not be additionally burdened financially – in the name of fairness. The overall effectiveness of the system was also calculated, taking into account the amount of resources allocated to health care. This general measure was calculated on the basis of two levels of implementation of objectives: firstly, effectiveness in the implementation of health objectives, and secondly,

effectiveness in the implementation of all objectives. The latter measure was the general basis for evaluation, which was the basis for qualification of systems as better in the specific understanding of quality and effectiveness adopted in the Report.

With the adoption of such a structure of objectives, treated as evaluation criteria, the Polish system was classified as follows: achievement of the health objective – ranked 45th, first place Japan, following Slovakia and Georgia, before Yugoslavia. Responsiveness – ranked 50th, first place the USA, following Mongolia, the Czech Republic and Philippines, ahead of Vietnam and Mexico. Fairness – ranked 150–151th, first place Colombia, Luxembourg, equal to Togo, Mauritania, the Dominican Republic and Zambia. In the health efficiency ranking Poland was ranked 89th, the first place was taken by Oman and Malta, following Slovakia and ahead of Indonesia. The Polish system was ranked 50th in the overall effectiveness assessment, with France taking the first place, Italy second, following the Czech Republic and Malaysia, ahead of the Dominican Republic and Tunisia.

Source: Euro Health Consumer Index EHCI⁴

The Euro Health Consumer Index (EHCI) is a mechanism for comparing the performance of European health systems, using a list of fixed, albeit slightly modified, indicators that are presented in the **Table I**.⁵ It has been in operation since 2005. This undertaking is implemented by an independent non-governmental organization. The Health Consumer Powerhouse (HCP) institute is based in Sweden. The analyses are based on available statistical data and questionnaires filled in by interviewers cooperating with the institute. The project is co-financed by several pharmaceutical and medical companies. It is worth noting that the EHCI has not been cooperating with the EU, is not widely supported by researchers, and is sometimes criticised [10].

In the 2009 ranking, Poland was ahead of Bulgaria, Romania, Latvia, Albania, Lithuania, Slovakia and Malta.⁶ In the 2012 ranking, Poland came eighth, ahead of Serbia, Bulgaria, Romania, Latvia, Macedonia, Albania and Hungary [11]. The situation in Poland did not receive any specific comment, except for a general remark about the obvious need for reform. In the 2018 ranking, Poland was ranked 32nd out of 35 classified countries, ahead of Albania, Romania and Hungary. The authors admitted that it is not easy to identify the reasons for the poor performance of the system. In a hypothetical explanation, it was pointed out that the attention of high-level decision-makers has recently focused on issues other than the desire to provide high quality health services to those in need. This lack of attention must have led to a worsening of the situation. Perhaps the shift in attention seen in the health sector was a consequence of a similar process within the government. This was to deal with issues such as suppressing the free press, politicising the judiciary, and insisting on not allowing even the smallest groups of migrants into the country.⁷ Poland was also mentioned as one of the three countries where there was

Indicator	2012	2014	2018
Patients' rights and information	Legislation based on patient rights, involvement of patient organisations, insurance against errors, right to a second opinion, access to own documentation, list of trustworthy doctors, 24-hour access to information, access to services abroad, ranking of healthcare providers, scope of use of electronic documentation, internet registration, e-prescriptions		Involvement of patient organisations in the decision-making process (correction)
Availability (waiting time)	Family doctor available on the same day, access to specialists without referral, important operations within 90 days, cancer treatment within 21 days, CT within a week, waiting time in emergency departments		Waiting time for child psychiatry services (added), waiting time in emergency departments (deleted)
Health effects	Reduction in CV mortality, reduction in stroke mortality, child mortality, survival in cancer, avoidable life years lost, hospital-acquired infections, undiagnosed diabetes, depression	Abortion rate (added)	Suicide rate, deaths before 65 years of age, diabetic patients with HbA1C > 7 (added); depression (removed)
Range of impact of the system	Fairness in the system, cataract surgeries/100 thousand kidney transplants/ 1/ million, public dentistry, mammography, informal fees for doctors, long-term care for seniors, % of non-hospital dialyses	Caesarean sections (added)	
Prevention	Childhood vaccinations (8 components), blood pressure control, smoking, alcohol, physical activity, HPV vaccinations, road traffic deaths		
Access to medicines	Reimbursement of prescription drugs, pharmacopoeia available to laymen, new cancer drugs, access to innovative drugs (introduction of reimbursement), drugs against Alzheimer's disease, schizophrenia, non-use of antibiotics against viruses	Anti-arthritis drugs, metformin, antibiotics (added)	Use of statins (added), use of metformin (deleted)

Table I. Structure of indicators in the Health Consumer Index.

Source: EHCI 2012, 2014, 2018 [11–13].

no women's right to decide on abortion. It was also noted that the ongoing discussions about the need for fundamental reforms in health care for many years had not led to an improvement in the situation (**Table II**).

The values obtained in the research do not allow to determine the direction of changes occurring in the Polish system in relation to other European systems. Although it is not possible to talk about a dramatic collapse, it is certainly difficult to decide about a radical or even minor improvement.

Source: OECD documents and studies

The slogan used in the title of this subsection comprises very different sources. On the one hand, these are statistical data made available on an ongoing basis, the advantage of which is a relatively small time lag. Further, regularly published studies of the Health at Glance series, which present data on the status of health systems of OECD countries, as well as Brazil, China, the Russian Federation, India, South Africa and several others. Subsequent studies are published every two years, alternating with texts on European issues. As written on the website The Health at a Glance: Europe report series gauges progress towards effective, accessible

and resilient health systems across the EU. These studies were initiated in 2010 and are published in two-year periods, presenting the facts that allow for the reconstruction of the situation in the EU area and partly in national systems. They are based on databases used in the Health at a Glance series and the Health systems in transition series published by the European Observatory on Health Systems and Policies, and the works are coordinated by the European Commission. They are further detailed in the profiles presenting the situation in particular countries. They are valuable since they focus on national issues and contain much more feedback from evaluators than is the case in more general studies. However, the disadvantage is the relative delay, which is understandable in that it is necessary that the reports contain and synthesise the gradually acquired information. The results of the European Union Statistics on Income and Living Conditions (EU-SILC), are also an important source of information and are used as a reference point for comparing statistics on income distribution and social inclusion in the EU. Among the OECD materials, there are also monothematic reports on a selected issue in the health sector, which contain information on different countries. The analysis of these documents allows us to identify four problems.

	2012			2018		
	Poland	Min.	Max.	Poland	Min.	Max.
Patients' rights and information	126 72%	Romania, Malta, Greece, Bulgaria 88	Denmark 175	79 56%	Albania, Greece 67	The Netherlands, Norway 125
Availability (waiting time)	117 50.2%	Norway 83	Belgium, Luxembourg Switzerland 233	138 61.3%	Spain, Hun- gary 113	Switzerland 225
Health effects	188 62.6%	Albania 113	Norway, Sweden 300	167 60%	Romania 133	Finland, Norway, Switzerland 278
Range of impact of the system	n.d.	n.d.	n.d.	57 45.6%	Albania 42	The Netherlands, Sweden 125
Prevention	99 60.7%	Albania 70	The Netherlands 163	89 74.7%	Romania 54	Norway 119
Access to medicines	48 53.3%	Albania, Bulgaria, Lithuania 33	Denmark 90	56 62.9%	Albania 33	Germany, The Netherlands 89

Table II. Detailed EHCI score and % of maximum value.

Source: EHCI 2012, 2018 [11, 13].

The first problem analysed on the basis of this group of sources is the issue of unmet needs. Health at Glance 2009 addresses unmet needs in relation to access to healthcare. The information was based on the statements of those respondents who said that over the past year there had been situations where they felt the need to contact healthcare professionals but could not obtain advice. This could be due to a financial barrier, the waiting time to be too long or living too far away from the healthcare facility. Based on information for 2007, Poland was ranked first in terms of unmet needs, both in general and in terms of dental care needs: more than 10% of respondents declared this problem. It was interesting to note that with regard to general needs, wealth had no effect on facilitating access, and so well-off people also encountered barriers. On the other hand, wealth had an impact on the use of dental services. With an average level of unmet needs of 7.5%, the unmet needs of poorer groups were much higher and close to 14%. In 2016, the level of unmet needs in the richest group was 4.5%, in the group with average income was 6.6%, but in the group of the poorest it reached 9.8%, with the EU average of 1.1%, 2.5% and 5%, respectively. Polish values of unmet needs were therefore higher than those of the EU in all categories. This meant Poland came ahead of only three of the analysed countries, preceding Estonia, Greece and Latvia. The position of Polish patients receiving dental services was better. Unmet needs were 1.7%, 3.7% and 6.6%, with EU averages of 1.2%, 4% and 7.9%, so the Polish rates were better.

In 2007, when the OECD document diagnosed a relatively high level of unmet needs, restrictions on formal access did not play a major role, and were estimated at 98.1% of the population. In 2016, the percentage of those formally insured was 91.5%. The established figures refer to the possession of general rights. However, it should be remembered that the content or scope of these rights is different when looking at various types of benefits. The size and content of actually available entitlements depends on the size of the public

payer's financial contribution, because it shapes the 'free of charge' character of health care perceived by patients. After all, it is easy to imagine that some benefits are formally available but practically unattainable, due to an impassable financial barrier. It could also be due to a extremely long waiting period. In 2016, the share of public funds in financing various types of services was as follows: hospital care 95%, ambulatory care 61%, dentistry 29%, medicines 34%, medical equipment 43%. The presented values allow us to claim that while hospital care is in principle fully financially available, other forms of care are available to a lesser or greater extent. This is particularly striking in relation to outpatient care, as it concerns first of all specialist services, in which a long waiting time leads many people in need to use services in private institutions, i.e. in return for payment.

The second problem analyzed on the basis of data from Health at a glance studies was the issue of self-assessment of health status by Poles, which, as we know, can only partially be treated as health status information. It is known that at least to some extent, the respondents' answers reflects the level of their optimism in the assessment of the general situation in the country or their own situation in life. However, it is worth using since this is routine information, which is also tangible in terms of its variability over time.

In 2001, 46.8% of respondents aged 15 and over (51.7% of men and 42.6% of women) declared good or very good health. At that time, the average EU values were 75% for the general population. Poland was ahead of five countries included in the study: Portugal, Slovakia, Japan, Hungary and Korea. Among the population of over 65 years of age, 13.4% of men and 8.1% of women, 10.1% in total, declared to be healthy or very healthy. These statistics meant that Poland was in the penultimate position, after Portugal.

In 2016, 59% of Polish respondents declared their health to be good or very good, with an EU average of 68%. In the group of well-off people, 72% of respondents declared the same (EU average – 78%, and in the group

of people with low income – 52%, with the EU average of 60%). Among the countries included in the analysis, Poland was ahead of four countries – Lithuania, Latvia, Portugal and Estonia.

The third analysed issue was the issue of the waiting time for selected procedures. In 2012/2013 the (median) waiting time for cataract surgery was almost 300 days and after Estonia it was the longest waiting time for surgery. At the same time, the waiting time for hip surgery was about 200 days (median), and as in the previous case, only Estonia was ahead of Poland. The waiting time for knee surgery was also the longest in that period of time.

The (median) waiting time for cataract removal in 2016 was 420 days, while the average time was equal to 484 days (last place among the countries presented). That year, the waiting time in Poland, including Estonia, was the longest among all analysed countries. The percentage of people waiting for this procedure for more than three months was 86% and an increasing trend was observed. The median hip joint implantation waiting time was 276 days, and the average time was 444 days (last place among the presented countries). As in the case of the previous procedure, Poland had the highest percentage of people waiting for more than three months – 88% – and it was growing. The information about the waiting time for knee joint surgery was not repeated.

The fourth problem was the quality of some services perceived by patients. In 2010, 64% of Polish patients declared that the general practitioner devotes sufficient time to patients, and this statistic placed Poland in the last position, while the first-ranked Czech Republic had a 97.2% rate. Three years later, the percentage for Poland fell to 59.6% (last place) while Belgium, ranked first, reached 97.5%. For the same years, answers were given to the question about the involvement of the patient by the doctor in the decisions concerning the diagnostic procedure and treatment. In the first survey, 50.2% of respondents gave a positive answer. This put Poland in the last position, while 95.6% of the respondents in Luxembourg gave a positive answer. In the second study, the answers confirming the involvement of patients by Polish doctors constituted 47.9%.

The general assessment of the quality of functioning of the family doctor or, more broadly, of health care at the basic level, allowed us to take the penultimate place in our system. Poland, with a score of 6.5 points, overtook Greece with 6 points, with an EU average of 7.3 points. It is worth noting that non-EU countries such as Albania, Macedonia, Montenegro and Serbia scored higher than Poland.

Source: CBOS surveys

In the survey conducted from 7 to 14 June 2018, 30% of respondents positively assessed the functioning of the health care system in Poland, including 2% who were very satisfied, and 66% who expressed critical opinions, including 27% who expressed a clearly negative opinion [15]. 4% of the respondents did not provide any opinion. At the beginning of 2001, 31% were satisfied,

including 4% at the maximum level. 64% were dissatisfied, of which 26% were extremely dissatisfied, and 5% had no opinion (Table III).

	Earlier	2018
Doctors are competent – they know what they are doing.	68% – 2012	70%
You can get access to the primary care doctor (Pol. POZ)* without difficulty.	85% – 2007	68%
Doctors get involved in their work – they want to help patients.	61% – 2012	65%
Modern medical equipment is used.	55% – 2012	59%
Even at night, you can count on immediate medical attention.	56% – 2012	58%
There is good information about where you can get advice or help.	51% – 2007	57%
Patients are treated with kindness and care.	75% – 2007	57%
Health care successfully uses modern solutions, e.g. the Internet.	32% – 2012	56%
Medical assistance is easily obtained also outside the place of residence.	39% – 2012	46%
Facility administration supports patients quickly and efficiently.	41% – 2012	44%
Doctors of various specialties and diagnostic laboratories provide services in locations convenient for patients – there is no need to look far to find them.	37% – 2012	43%
Night and holiday care works well, too.	not investigated	41%
All patients are treated equally, depending only on their state of health.	48% – 2007	39%
Treatment is free of charge.	52% – 2012	35%
You can easily arrange an appointment for a convenient hour, so that you do not have to miss work/lessons/classes, for example.	30% – 2012	34%
The necessary diagnostic tests can be carried out quickly and without major difficulties.	25% – 2012	29%
The number of medical staff in hospitals is sufficient.	not investigated	13%
If the patient needs it, it is easy to get to a specialist for an appointment.	11% – 2012	13%

Table III. Percentage of positive responses.

Source: CBOS 2018 [15].

The size of the positive response rate only partially reflected the opinions of the respondents. In fact, nearly half of the respondents were critical of the speed and efficiency of patient service provided by the administration of facilities (49%) and the observance of the principle of equal treatment of patients. Similarly, the location of facilities where services are offered was assessed negatively (52%). More than half of the respondents noticed difficulties in making an appointment at a convenient time (58%) and disagreed with the statement that treatment is free of charge (61%). Very many respondents declared dissatisfaction with the long waiting time

for diagnostic tests (66%) and the insufficient number of medical staff in hospitals (70%). The availability of specialists was assessed exceptionally negative: 83% perceived barriers to the use of these services. The declared motives for using services outside the public system are a good verification of ailments connected with limiting access to specialists: 74% of those benefiting from privately paid benefits claimed that they acted in this way due to shorter waiting times [16]. It is also worth noting that the existence of accessibility barriers is not a new problem. In a survey conducted in 2001, i.e. two years after the implementation of a major health system reform, 35% of respondents indicated these barriers as a significant nuisance [17]. 19% of respondents explicitly mentioned “facilitating access to specialist doctors, including shortening the time of waiting for consultation” as the most important problem to be solved.

Comparisons with previous periods bring a less systematized knowledge, especially in the absence of systematically conducted research bringing comparable results. Therefore, only partially can we conclude that it is likely that the assessment of the ease of getting to the primary-care (*POZ*) doctor will decrease, that patients will be treated less favourably and with less care, and that they will be treated equally. The percentage of respondents perceiving the activities of the health care system as free of charge also decreased. It is difficult to decide whether, in this situation, increased appreciation of doctors’ competences should be treated as compensating for the perceived shortcomings.

The issue of the expenditure involved requires additional comment because it has a different meaning in public and non-public health care. In the former type, the reason for expenses are subsidies to medicines, equipment or co-payments in nursing homes and possibly informal payments, i.e. bribes, while in the case of privately provided services, fees are a natural element of transactions concluded on a voluntary basis, although different circumstances, such as queues and limited availability, may be an important reason for them. It is therefore clear that private provision by nature cannot be seen as free of charge and that the frequency and intensity of use has a significant impact on household burdens. The results of a survey repeated after several years are presented in the table below [18].

The results presented allow a clear conclusion to be drawn about a very significant increase in the use of

private benefits. This is despite the fact that there is sometimes a significant financial barrier. With regard to dentistry, there is the impression that there are residual public benefits in this area, but that access to professionals is often conditioned by the necessity to use a private provider (**Table IV**).

The problem of financial barriers was investigated in the early 1990s, when new solutions were sought that could be applied in the reformed health care system. The term ‘affordability’ for private benefits was then coined, while the term ‘free’ for the public system remained unchanged. The survey conducted in 1993 found that although the majority of respondents perceived the predominance of private benefits – professionalism, accessibility, and even equality – only 16% said that the prices paid for these benefits were affordable [19]. At the same time, 61% considered that public benefits are free of charge.

Source: National Health Fund (*NFZ*)

According to the Act, the National Health Fund is to be primarily a payer. In accordance with the way health systems are constructed in developed countries, institutions providing money to healthcare providers who distribute benefits to entitled persons are practically always established. However, in Polish practice, the role of the *NFZ* goes beyond the role of a money remitter and includes a clear influence that can be attributed to health policy. It consists in the fact that the content of agreements concluded with healthcare providers determines the actual scope of benefits that can be used by entitled persons. The fact that a benefit is not covered by a contract or such a restriction of current limits, postponing the time of its implementation to a distant future, practically eliminates access to this benefit. For this reason, the assessment of the situation by the National Health Fund and the manner of defining problems by this institution may sometimes have a fundamental impact on the situation of patients.

In the *NFZ* report for 2004 [20] reference was made to the complaints of the insured submitted to the voivodship branches and the *NFZ* Headquarters, which indicated “long waiting periods for specialist examinations and consultation with specialist doctors, according to the insured” (p. 68) and “long waiting times for clarification by healthcare providers” (p. 69). However, these were not stand-alone opinions presented by the authors of the report. Such opinions included the finding of an insufficient number of control checks carried out, due to “staff shortages – lack of professional staff assigned to this task” (p. 62).

In the Report for 2013 [21] the problem of “long waiting times for healthcare services” appeared and this issue concerned both outpatient and hospital services (p. 62). The document states that there is a “growing trend in the number of people waiting for healthcare, as well as an increase in the average time spent waiting for a given benefit, while limiting the financial resources available to the *NFZ*” (**Table V**).

	2002	2018
Of a general practitioner	8%	15%
Of a specialist doctor	17%	54%
Of an analytical laboratory		42%
Of a diagnostic laboratory (ultrasound, tomography, gastroscopy, etc.)	9%	36%
Of a dentist or dental laboratory	25%	82%

Table IV. Receipt of benefits outside the *NFZ*.

Source: CBOS 2002, 2018 [15, 18].

Type of clinic	Number of persons waiting	Waiting time			% of units with an average waiting time of 0 days
		Median I quarter	Median IV quarter	3 quartile	
Ophthalmology	314 226	33	40	83	18
Cardiovascular	142 181	60	79	131	9
Neurological	139 838	26	30	61	19
Trauma and orthopaedic surgery	136 223	23	28	50	14
CT	107 743	26	43	65	13

Table V. Number of patients waiting and expected waiting time (in days) – stable cases 2013.
Source: NFZ Report 2013 [21].

Type of clinic		Number of persons waiting	Waiting time	
			Median	3 quartile
Endocrinological	U	5961	18	64
	S	92 140	230	339
Neurosurgical	U	2757	27	79
	S	28 024	156	254
Cardiovascular	U	8746	11	33
	S	118 075	115	199
Gastroenterological	U	2255	7	31
	S	41 196	85	158
Ophthalmology	U	4938	0	6
	S	265 506	67	138

Table VI. Number of patients waiting and expected waiting time (in days) – urgent and stable cases December 2015.
Source: NFZ Report 2017 [22].

Type of clinic		Number of persons waiting	Waiting time	
			Median	3 quartile
Endocrinological	U	3515	7	36
	S	88 230	169	246
Neurosurgical	U	836	6	28
	S	23 246	109	197
Cardiovascular	U	4579	5	20
	S	114 602	100	175
Gastroenterological	U	1116	1	14
	S	39 890	76	132
Ophthalmology	U	2928	0	2
	S	270 780	60	122

Table VII. Number of patients waiting and expected waiting time (in days) – urgent and stable cases December 2017.
Source: NFZ Report 2017 [22].

Type of clinic	Number of persons waiting	Waiting time		% of units with an average waiting time of 0 days
		Median	3 quartile	
Trauma and orthopaedic surgery	110 561	100	202	17
Otorhinolaryngological	74 484	93	143	8
General surgery	58 668	29	58	26
One-day treatment	23 683	15	51	32
Neurosurgery	21 163	85	153	9

Table VIII. Number of patients waiting and expected waiting time (in days) – stable cases 2013.
Source: NFZ Report 2013 [21].

A worrying phenomenon was not only the long waiting time for benefits, but also the occurrence of the queues getting longer. In all the presented types of institutions, the waiting time increased, sometimes almost twice as much as in the case of waiting for CT scans. At the same time, the percentage of institutions where it was possible to obtain consultation without a queue was very low.

Information on waiting times in subsequent years is presented in **Tables VI** and **VII**.

In the 2017 report a minor methodological change was introduced in the way the information was presented:

the tables distinguish between urgent and stable cases (previously only stable cases were reported). This was an important change since in stable cases a long waiting time may be reasonable (as long as it is not excessively long) – the queue may be a tool for planning the process of using the services and the patient does not suffer any damage to their health, but in urgent cases any delay is unacceptable.

It should be pointed out that the median waiting time in urgent ophthalmic cases was 0, bearing in mind, however, that the measure of waiting was days, not hours, but it could be disturbing that in cardiology the median

waiting time in such urgent conditions was five days. Overall, the situation in 2017 was better than two years earlier, but compared to 2013 there has been no improvement: in the cardiology clinic there was a change from 79 days to 100 days, in the ophthalmology clinic from 40 days to 60 days.

Type of clinic		Number of persons waiting	Waiting time	
			Median	3 quartile
Trauma and orthopaedic surgery	U	17 753	17	56
	S	124 643	128	268
Paediatric Otorhinolaryngology	U	581	16	65
	S	12 295	163	217
Otorhinolaryngological	U	2 788	7	25
	S	93 353	131	207
Neurosurgery	U	5 121	15	49
	S	26 444	99	275
Rheumatological	U	2 689	16	32
	S	15 441	79	173

Table IX. Number of patients waiting and expected waiting time (in days) – stable cases, December 2015.
Source: NFZ Report 2017 [22].

Type of clinic		Number of persons waiting	Waiting time	
			Median	3 quartile
Trauma and orthopaedic surgery	U	26 657	32	64
	S	133 768	166	335
Paediatric otorhinolaryngology	U	812	23	46
	S	12 372	168	219
Otorhinolaryngological	U	3 548	7	38
	S	102 105	152	252
Neurosurgery	U	6 489	29	62
	S	31 043	112	268
Rheumatological	U	2 873	18	38
	S	14 234	68	189

Table X. Number of patients waiting and expected waiting time (in days) – stable cases, December 2017.
Source: NFZ Report 2017 [22].

Comparison between the new data and those of 2013 is not possible due to the differences in the branches that were taken into account in the subsequent statements. On the other hand, the situation in the last two years has rather deteriorated. Only in one case did the waiting time become reduced. This was also the case for one urgent case in the paediatric otolaryngology department (3 quartile) and one stable case in the neurosurgery department (3 quartile). Such changes could not be considered as a sign of improvement (**Table VIII–X**).

Source: Reports of the Supreme Audit Office

One important source of information is the Supreme Audit Office (Pol. *NIK*) reports. As it is written in the official vision of this institution, its “reports will be a welcome and sought-after source of information for authorities and the public”. Referring to the present rather than the future, it can be noted that the long-standing independence of the Supreme Audit Office made it possible to treat the reports as a reliable basis for knowledge about what goes on in the health system. In its previous practice, the *NIK* prepared two types of reports. The first type of reports are synthetic reports, where an attempt was made to present the general situation in the system. In the latest report of this type, dated May 2019, it was stated that the main problem faced by the system’s patients is “difficult access to services of appropriate quality [23]”. Three complex causes have been identified which have led to this unsatisfactory effect:

- uncoordinated activities concerning the establishment and functioning of medicinal entities;
- uncoordinated patient care;
- insufficient or inadequate resources of the system to meet current and future health needs of the population.

A number of detailed recommendations were presented, which, if applied in a planned and systematic manner, should – quite possibly – contribute to a radical improvement of the situation. It should be added that the report also includes a list of numerous (71 studies), detailed reports on health care services, reports that have been prepared by the Supreme Audit Office over the years and used in the preparation of a synthetic study.

An example of a monothematic report could be the study titled “Medical care for the elderly [24]”. As the report says: “The idea is that geriatrics should offer the patient holistic care from a multidisciplinary team of professionals in order to optimise the health of the elderly, their autonomy and their quality of life.” Unfortunately, the analysis of the situation in Poland showed it to be far from ideal.

Source: WNC BAROMETER

The first published Report states that in February and March 2012 the waiting time increased by 0.2 months compared to December 2011 and January 2012, and amounted to 2.7 months.⁸ In addition, it was established that in 18 specialties the waiting time was extended: in diabetology the waiting time was extended from 1 to 6.4 months, in endocrinology the nearest consultation dates were set for 7 months. Access to vascular surgery services deteriorated: the waiting time for a consultation with a vascular surgeon – 7.1 months, waiting time for a consultation with a hepatologist – 4.9 months, and for a colonoscopy – 2.8 months.

In December/January 2019, the average waiting time for a single guaranteed health service was 3.8 months (about 16 weeks) [26]. The list of specialties in which the waiting time exceeded the six-month period is presented in the **Table XI**.

	2019
Endocrinology	11.6
Orthopaedics and traumatology	10.9
Dentistry	8.2
Pediatric cardiology	7.3
Neurosurgery	7.1
Rheumatology	7.0
Plastic surgery	6.9
Angiology	6.8
Immunology	6.5

Table XI. *Waiting time in selected specialties (in months).*
Source: WHC BAROMETER 2019 [26].

When presenting data on the length of queues for guaranteed benefits, i.e. benefits belonging to a benefits package, the availability of which should be of particular concern, it is worth noting that the institution monitoring this issue is a non-governmental organisation. It should be fully appreciated that the investigation of such an important issue is carried out by an NGO.

Summary

It is easy to notice that the above mentioned sources of information do not include home statistical data, including yearbooks. Their omission was the result of the decision to use only the information that seemed necessary to present the diagnosis – in the meaning adopted. Undoubtedly, statistical yearbooks contain a great deal of valuable information, but this is the type that can be useful in explaining some phenomena, as I have already written in relation to insufficient resources, and not in the description. Therefore, when the search for problem-solving methods is addressed, the use of yearbooks will be obvious and necessary. Having provided this explanation, I can move on to the summary as such.

In the WHO report, based on the data from the previous century, the rank of the Polish system was not impressive. Although the overall effectiveness was assessed at an average level, a very low position on the scale of justice was a surprise, especially considering the principles of public financing of health care. Also, the achievement of health objectives was rather disappointing, bearing in mind the effective fight against infectious diseases, including tuberculosis. While those evaluations can now be considered historic, identifying what structure of indicators was the basis for negative evaluations could play a constructive role in the future.

From the EHCI Report, it is worth taking the structure of the indicators, also regardless of the rules adopted for their grouping. The selection of indicators can be treated as a set of guidelines showing potential deficiencies and dysfunctions of the system. In the previous assessments, the Polish system scored very poorly in this category, but nowadays it is worth noting the country's poor achievements in such aspects as justice in the system or

long-term care for the elderly. The first problem would be a repetition of the bad assessment in the WHO Report, while the second issue is known to be a very neglected area of care.

Opinion polls on the operation of the health system have shown many critical opinions. Although there is no clear trend of growing dissatisfaction, the predominance of dissatisfaction is a permanent phenomenon. More detailed answers allow us to determine the main causes of dissatisfaction. The most painful are the barriers to access to specialists: there are nearly no respondents claiming the access is easy. Patients also see an insufficient number of medical staff in hospitals and problems with using diagnostic tests. Information on the use of self-financed services, forced by long waiting times for public funding, confirms the despair of patients suffering long waiting times.

Bad information about availability and queues is confirmed in NFZ reports. For several years now, the national payer has been reporting increasingly long waiting times for many specialist services, both in the process of diagnosis and treatment. The situation was unfavourable, for example, in endocrinology clinics, where the waiting time exceeded one year, or in referrals for diagnostic imaging. Equally unfavourable situation was in hospital care. Subsequent reports brought information about the worsening of the situation rather than its improvement. Speaking about the way of referring to the problem of long queues in subsequent reports, one can see a decrease in the 'emotional temperature' that was visible in the content. While in 2013 the term 'queue' was used rather decisively, in later reports the language was softened.

Valuable information was provided by the WHC BAROMETER. Systematically prepared reports focusing on the problem of queues are a valuable source of information. The fact that NGOs have taken this initiative legitimises expectations that the data provided are impartial and do not serve the interests of those who might be interested in presenting a more optimistic picture.

OECD studies have also provided information on issues that are neither routinely examined in Poland nor always perceived as important enough to be disclosed to the public. Such a problem is the issue of unmet needs related to limited access to health care. One of the reasons is the lack of formal rights – and this reason is raised by the authors of the study – but often the reasons are more mundane – long waiting times, distance or financial barriers. For an effective health policy – effective, meaning one that guarantees every person in need the possibility of obtaining professional care – the occurrence of any of these causes should be interpreted as a challenge. A relatively high level of non-satisfaction should be taken seriously. Another very important problem is extended waiting times. Previously presented information confirmed the importance of this issue for both patients and policy makers in the system, and OECD data provide complementary support. It consists in indicating queues for selected procedures, which on the one hand are important for the users, but also have an indicative value. The value of these indicators is increasing, which means

the situation is worsening. Equally important is the quality of services, in the sense that they do not comply with the medical standard, but with the climate of mutual relations perceived by patients. Time devoted to the patient by the doctor, willingness to talk to him or her and to alleviate anxiety are important correlates of this situation. Paying attention to the role of such aspects of therapeutic relations seems to be a big challenge for our system.

Conclusion

The information provided herein, taken from publicly available sources, provides clear evidence of the feasibility of making documented diagnoses of our health system – at least to some extent. On the basis of the data collected in these sources, there is a full possibility of deciding what can and should be treated as a problem to be solved. It seems that if the available information were used for diagnostic purposes before taking various reform decisions, the probability of accurate decisions would increase significantly. Of course, after supplementing the diagnostic stage with a phase of explanation. The use of available information for explicative purposes will be discussed further – in the next paper.

Notes

¹ Earlier versions of this paper were presented on a number of conferences: Commissioned “Lecture of the year”, The conference in the cycle “How to improve Poles’ health”. Polish academy of Sciences, Public Health Committee, Royal Castle, Warsaw, December 8, 2014; The Conference of the Polish Cardiology Society “Quo vadis Cardiology”, Serock, June 26, 2015; X Congress of Medical Polonia and III World Physicians Meeting, Gdansk, May 30, 2019.

² E.g. the publication made public in January 2019 contained data for 2017, *Zdrowie i ochrona zdrowia w 2017* [Health and health care in 2017], GUS, 2019; <https://stat.gov.pl/obszary-tematyczne/zdrowie/zdrowie/zdrowie-i-ochrona-zdrowia-w-2017-r-,1,8.html> (accessed: 12.04.2019) [6].

³ WHO, *The World Health Report 2000. Health Systems: Improving Performance*, WHO 2000, p. 5 [8].

⁴ The information from EHCI about Polish health care is presented to general public, e.g. *Polski system ochrony zdrowia to jeden z najgorszych w całej Europie* [The Polish health protection system – one of the worst in all Europe], “Newsweek” 8.03.2019; <https://www.newsweek.pl/polska/polski-system-ochrony-zdrowia-to-jeden-z-najgorszych-w-calej-europie/ysmwzfp> (accessed: 11.04.2019) [9].

⁵ Health Consumer Powerhouse, cf. <https://healthpowerhouse.com/> (accessed: 21.04.2019).

⁶ Euro Health Consumer Index 2009, Tallinn, November 18 2009; http://www.praxis.ee/fileadmin/tarmo/Projektid/Valitsemine_ja_kodanike%C3%BCChiskond/Kodanike_ja_poliitikakujundajate_dialog_V%C3%9CF/Ettekanne_Arne_Bjornberg.pdf (accessed: 05.05.2019) [14]; I cannot provide more detailed information about this ranking, because I only had access to the presentation, and not to the full text of the Report.

⁷ “In recent years, the governments seem to have focussed on things other than the optimal running of the country, such as killing off the free press, politicizing the judicial system, keeping out also

very modest quotas of migrants...”, Euro Health Consumer Index 2018; <https://healthpowerhouse.com/media/EHCI-2018/EHCI-2018-report.pdf> (accessed: 05.05.2019) [13].

⁸ All services, regardless of their nature, diagnostic or therapeutic, were taken into account. The complexity and the necessary step-by-step approach to treatment were not taken into account, BAROMETR WHC, Raport na temat zmian w zakresie dostępności do gwarantowanych świadczeń zdrowotnych w Polsce no. 1_1_2012 As of Feb/March 2012; http://www.korektorzdrowia.pl/wp-content/uploads/barometr-whc_1_1_2012.pdf (accessed: 18.05.2019) [25].

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